Alabama Medicaid Agency

Oxygen Therapy

Request for Prior Authorization and Prescription

Patient Information

Patient Name: _____ Patient Medicaid Number: _____

Date of Birth: _____ Diagnosis: _____

Prescription Information

Date last seen by physician: _____

Date oxygen prescribed: _____ ☐ Initial ☐ Renewal

Liters per minute: _____ Minutes per hour: _____ Hours per day: _____

Method of delivery (nasal cannula, mask, etc.): _____

If portable oxygen prescribed, state purpose: _____

Estimated length of time oxygen needed: _____ (months)

Describe type, duration, and frequency of recipient's daily activities outside the home:

_____

_____

Equipment Prescribed

Stationary System

- ❑ Compressed Gas
- ❑ Oxygen Concentrator

Portable System

- ❑ Compressed Gas

Laboratory Results

ABG (PO2) result _____ ☐ Room Air ☐ Oyxgen Date of test: _____

Oxygen Saturation _____ ☐ Room Air ☐ Oyxgen Date of test: _____

Must attach a copy of the ABG report or oxygen saturation readout. ABG not required for children.

If ABG was not performed, please explain: _____

If test not performed on room air, please explain: _____

If ABG exceeds 59 mm Hg or if oxygen saturation exceeds 89 percent (**94 percent for children three and under**), physician must justify need for oxygen with more medical information.

_____

_____

_____

(A separate letter may be attached if more space is needed to justify medical necessity)

The request for prior authorization must be submitted within seven (7) working days of the beginning of the service. All requests received beyond this time frame will be authorized for reimbursement effective the date of receipt by EDS.

I certify that oxygen is medically necessary.

Physician Signature: _____ Date: _____

(Stamped signatures are not acceptable)